**OFFICE OF LABORATORY SERVICES**
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

*PLACE BARCODE HERE*

*OLS USE ONLY*

# SARS-CoV-2 (COVID-19) MOLECULAR SEQUENCING SPECIMEN SUBMISSION FORM

## PATIENT INFORMATION

| | | |
|---|---|---|
| PATIENT ID (Chart #, MRN, etc.) *MAX. 17 CHARACTERS* | | |
| LAST NAME | FIRST NAME | MI |
| DATE OF BIRTH | SS# *(last 4 only, optional)* | |
| COUNTY OF RESIDENCE | SEX (at birth) ❑ Female ❑ Male | |
| STREET ADDRESS | | |
| CITY | STATE | ZIP |
| PATIENT PHONE NO. *(optional)* | | |
| RACE ❑ White ❑ Asian ❑ Black ❑ Other _____ ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander | | |
| ETHNICITY ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Unknown | | |

## SUBMITTER INFORMATION

| | | |
|---|---|---|
| FACILITY NAME | | |
| MAILING ADDRESS | | |
| CITY | STATE | ZIP |
| COUNTY | | |
| ATTENTION TO | | |
| PHONE NO. | | |
| FAX NO. | | |

**COMMENTS:**

| OLS USE ONLY | |
|---|---|
| ❒ UNSAT \| Reason: | ACC: |
| ❒ SATISFACTORY | DE: |
| | CKD: |

## DATE OF COLLECTION:

**SOURCE OF SPECIMEN:**
❑ Nasopharyngeal *(other sources not acceptable)*

**TEST(S) REQUESTED:**
❑ SARS-CoV-2 genomic sequencing

**SUBMITTED FOR:**
❑ Epidemiology Request ❑ Surveillance
❑ Outbreak Investigation (**complete information below*)

**REQUIRED OUTBREAK INFORMATION***
OUTBREAK NUMBER _____ (from DIDE)

| | |
|---|---|
| ❑ Nursing Home / LTCF | ❑ Daycare |
| ❑ School | ❑ Other |

**REQUIRED PATIENT INFORMATION:**
**Illness Status** ❑ Symptomatic ❑ Asymptomatic
Symptom Onset Date: _____ / _____ / _____
Patient Level of Care: ❑ Inpatient ❑ Outpatient
Travel History (outside WV):
Travel History (outside US):
Date(s) of Travel:
Did patient receive the vaccine?: ❑ Yes ❑ No

| | |
|---|---|
| Date of 1st dose: | Date of 2nd dose: |

**REQUIRED SPECIMEN TEST INFORMATION:**
Was specimen tested using qRT-PCR? ❑ Yes ❑ No
Ct value:
Date Tested:

**OLS USE ONLY**
**Was sample frozen?** ❑ Yes ❑ No
**SAMPLE CONDITION:**
❑ Ice Packs ❑ Frozen ❑ Room Temperature
**VTM/UTM Volume:** ❑ 3mL ❑ less than 3mL

**FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS**